gature was very readily passed under the artery from below, and its blunt extremity having been pressed upwards, I cut through the cellular tissue upon it, and thus passed the instrument without detaching the vessel from its connexions. The ligature was tied with great ease, and the tumour immediately subsided. All pulsation ceased from that time; the edges of the wound were brought together by means of a suture and some adhesive plaster, and the patient returned to her bed. She bore the operation with remarkable firmness throughout."

Nothing requiring notice subsequently occurred. The ligature on the artery came away on the 20th of May, and up to the date of the report, (November,) the patient had enjoyed perfectly good health, and felt no inconvenience from the operation.

The following circumstances Mr. N. considers of some importance:—

" *The position of the patient,* who was placed horizontally, with the head, (as described,) hanging over the end of the table, which position contributed very materially to facilitate the different steps of the operation. The space is thus completely exposed; the light falls fully on the part where it is of the most importance; and the operator is not confused by the presence of any accumulation of blood at the bottom of the wound.

" *The turning back of the jugular vein imbedded in the flap,* thus placing it beyond the chance of injury at the time of, or subsequently to, the operation.

" The practicability of performing this operation *without detaching the sterno-cleido-mastoid muscle from its clavicular origin,* although the tumour was situated above the clavicle.

" *The drawing upwards of the transverse artery,* and thus leaving it undivided, by which this vessel, (becoming enlarged as the circulation in the extremity grows more free,) becomes one of the principal trunks in subsequently supplying blood to the limb.

" *That no unfavourable symptoms* were produced by the division of, and tying, the accompanying vein, which in this instance could not be avoided.

" Lastly, the passing the aneurismal needle under the vessel, *without separating it from its connexions, which may be readily effected; and of tying it beneath the outer fibres of the scalenus,* which fact appears to me valuable, inasmuch as it proves, that the very short distance between the ligature and the thyroid axis, affords sufficient space for the formation of a coagulum, and the consequent obliteration of the arterial tube."

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30. *Clinical Lecture of M. Dupuytren on Retraction of the Fingers.*—M. Dupuytren, several months ago, directed the attention of his pupils to the subject of permanent flexion of the fingers, and the different causes of the deformity. Writers, in general, have only treated of that species of flexion of the fingers which is occasioned by hardened cicatrices from burns on the palm of the hand. M. Boyer, in his work on Surgery, briefly refers to the subject, and attributes the retraction of the fingers to a *crispatura tendinum.* The real causes and proper treatment of such cases were unknown, until M. Dupuytren discovered that the presumed contraction of the tendons was nothing more than contraction of the palmar aponeurosis, the division of which would immediately remove the deformity. At this time there was every reason to believe that this affection of the aponeurosis was accidental; the causes of it appeared evident, inasmuch as it existed usually in persons who were obliged to make frequent and violent efforts with the palm of the hand. Additional facts, however, have shown that this contraction of the aponeurosis may be not only congenital, but also hereditary. In July, M. Dupuytren was consulted in the case of a child, six years of age, who had a permanent retraction of the little and ring fingers. There were no traces of cicatrix or burn; but, when the fingers were forcibly bent backwards, the extended aponeurosis raised the skin like a tight cord, and left no doubt as to the diagnosis. In this instance the deformity was congenital;

the grandmother of the child had also been born with the same deformity. But, independent of retraction of the aponeurosis, and cicatrices upon the palm of the hand, other causes may also give rise to rigid contraction of the fingers, and different modes of treatment may be required. M. Dupuytren, for example, enumerates white swelling upon the joints of the fingers, and their consequent anchylosis; deformity of the articular surfaces from the effect of certain trades; the existence of serous cysts in or near the articulations; wounds of the flexor tendons; and paralysis of the extensor muscles. A case recently occurred at the Hôtel-Dieu from a different cause. The following is a brief account of it.

Retraction of the Middle Finger, in consequence of Adhesions of the Extensor Tendon. Division of the Tendon; Cure.—Virginie Lecord, three years old, had, at the age of a year, several small abscesses upon the lower third of the back part of the forearm. The two cicatrices that remained appeared too large for simple boils; but whatever might have been the nature of the abscesses, there was a cicatrix on the lower part of the forearm, outside the extensor tendon of the fingers, and a second inside the tendon, about half an inch lower down. The tendon formed a projection under the skin like a hard and rigid cord; the hand was bent backwards so as to form an obtuse angle with the back part of the forearm. The fingers were habitually in a flexed position; and it was only for a short time that the child had gained the power of voluntarily extending them. The state of the middle finger was different from that of the others; the first phalanx of it being bent much more backwards than the others; whilst the two other phalanges were rigidly flexed. In producing extension by force, the third phalanx was extended upon the second, but the latter remained obstinately bent upon the first.

M. Dupuytren regarded this as a very remarkable fact: the cause of the flexion existed neither near the joints nor the palm of the hand, but upon the back part of the forearm. There was no difficulty in explaining this apparent anomaly. In consequence of inflammation of the neighbouring parts, there were morbid adhesions and retraction of the extensor tendon, which satisfactorily explains the immoderate extension of the hand and first phalanx. But this forcible extension, this bending of the hand backwards, produced an unusual elongation of the flexor tendons and muscles, which were constantly endeavouring to regain their natural length; hence the habitual flexion of the fingers; but the extension being more powerfully exerted upon the middle finger, and pulling backwards the first phalanx, the action of the flexors, which could only act upon the two other phalanges, bent them inwards with still greater force. Every one may ascertain the validity of this explanation upon his own person. When all the muscles are in a state of repose, the fingers are more or less flexed, and they cannot be extended without bringing the flexor muscles into a greater or less degree of tension. If extension is forcibly produced, the tension of the flexors is augmented, and there is a degree of extension at which the hand cannot be forced further backwards upon the wrist, without flexion of the phalanges occurring in spite of any voluntary efforts to prevent it.

In the above case, the treatment, said M. Dupuytren, was obvious. It was necessary to divide the bridles which held the extensor tendon, and prevented it from yielding to the power of the flexor muscles, and perhaps also to divide the tendon itself. This division was made in the simplest manner; the tendon was exposed and cut across, and a part of the bridle, which was formed of a fibrous elastic tissue, was removed. The hand was immediately restored to a state of moderate extension; the middle finger was bent back, and the parts were maintained in position by an appropriate apparatus.

In fifteen days the little patient was discharged from the hospital entirely cured of the deformity. M. Dupuytren suggested that other causes would be discovered of this affection. It is very possible that the flexor muscles might be attacked with spasm, analogous to that which sometimes affects the sterno-mastoidean, and which necessarily draws down the head, and forcibly raises one shoulder. Some authors have pointed out a flexion of the finger as a symptom of luxation of the wrist, but M. Dupuytren doubts the existence of this injury.—*Gaz. Med. Tom. III. No.* 101.

31. *Injury of Hip-joint, and Secondary Luxation into the Ischiatic Notch.*—The following rare and interesting case is related by Mr. Ward. A tall but not very muscular shoemaker, aged forty, was admitted into St. Thomas's Hospital September 27th, having received an injury on the hip-joint from a fall. On admission he stated, that while walking on the pavement a month before, he slipped from the curb-stone, and fell with the whole weight of his body on the left hip, which part, he thinks, struck against the edge of the stone. On attempting to rise he again fell, and struck his knee. He was taken to Guy's Hospital and examined, but neither fracture nor dislocation being made out, he was dismissed. On the following morning he was brought to St. Thomas's Hospital. No fracture nor dislocation could be detected; he complained of a good deal of pain in and about the hip-joint, for which he was cupped freely and dismissed. After this he obtained admission into St. George's Workhouse as a pauper, where he was again carefully examined by the parish surgeon, but with the same result. He remained here a month, suffering very severe pain at times; kept his bed, and had the parts fomented frequently. He also states, that the day after the accident he could perceive that the left leg was a little shorter than the right; he could, however, bring the foot to rest on the ground when in the erect posture, by holding any thing to support him, though he could not bear the weight of his body on that leg, nor advance it before the other. He continued to suffer pain in the hip all the time he was in the workhouse.

He was seen on the day of admission by Mr. Travers, who examined him standing and lying down. Both legs were of exactly the same length, the left knee a little more advanced than the right; no alteration could be observed in the appearance of the hip-joint, and the contour of the buttocks was uniform. He could not raise the left thigh from the bed without the assistance of his hands; when standing erect he brought the foot and heel to the ground, but could not bear any weight on it, nor advance it before the other; he had a constant pain in the hip, extending down the thigh to the knee.

Directed to remain quiet in bed, and apply a large blister over the hip-joint.

The following week he still complained of pain; the blister was therefore repeated, and with considerable relief.

A third blister was applied to the outer side of the thigh. On Thursday, November 15th, the man's lameness continuing, Mr. Travers again examined the limb, and was much surprised by the following appearances. The injured thigh was found more than an inch shorter than the other; the knee raised and inverted; the foot also turned in; the great trochanter forming a remarkable prominence on the outer and back part of the gluteal region. Rotation outwards caused considerable pain, and the head of the bone could be distinctly felt to strike against the part on which it rested. The thigh could be carried backwards and outwards to some extent, but not inwards or forwards.

The nature of the injury, as it now existed, was very evident; and although a period exceeding three months from the time of the accident had elapsed, Mr. T. determined to attempt the reduction. He was therefore taken into the operating theatre, and placed on a table on his right side, a padded girth passed so as to fix the pelvis, which was then made secure by a cord to a fixed point; a linen roller applied round the thigh, and the padded strap buckled round above the knee, to which the pullies were attached. Extension was then made across the lower part of the right thigh for twenty minutes, without any change being produced. A vein in the arm was opened, and thirty ounces of blood taken. The extension was kept up, and doses of tartarized antimony administered for a considerable time; but neither sickness nor syncope induced. During the extension the leg was rotated, and an assistant endeavoured to raise the